



# SUICIDE AND COMPULSIVE GAMBLERS

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- What we are preventing
- The scope and significance of the problem
- Treatment
- Clinician Survivorship

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# Suicide is About Life

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- Suicide is about the despair that problems cannot be solved – no one will help.
- Suicide is about the decision to act destructively toward oneself.
- Suicide is fundamentally interpersonal even if the person is isolated and feels alone.
- Death and attempts are the way we count.



# Some People Die by Suicide – BUT.....

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- For every death and dangerous suicide attempt there are at least 6 people whose lives are profoundly affected.
- For every death there are at least 25 people who have survived an attempt
- MANY, MANY people live distracted lives with their thoughts of suicide.
- Each person lives in a family or with close people who are also impacted.
- SUICIDE IS ABOUT ALL OF THIS



# DEFINITION OF SUICIDE - I

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- Suicide is intentional self-murder (Maris in Maris, Berman, and Silverman, p. 30)
  - It is a death, not about non-fatal acts
  - It is intended
  - It is done by oneself and to oneself
  - It can be indirect or passive

From: Maris Berman, and Silverman (Ed), Comprehensive Textbook of Suicidology, New York, The Guilford Press, 2000.



# The Form of Suicide Theory

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- Completed suicide is directly related to the level of one's hopelessness and depression (in managing the human condition).
- Suicidal hopelessness, depression and dissatisfaction are directly related to the use of lethal methods.



## The Form of Suicide - 2

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- Suicidal hopelessness is directly related to depression, repeated life failures, prolonged negative interaction, and social isolation.
- Repeated depression, failure and negative interaction and social isolation are directly related to early trauma and to multiproblem family of origin.



# The Form of Suicide - 3

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- Age, male sex, and Protestant religious preference are directly related to completed suicide.
- Age and male sex are directly related to suicidal hopelessness, lethal methods, work problems, and physical illness and inversely related to satisfaction, repeated depression, negative interaction, sexual deviance, marital problems, drug problems, early trauma, and a multiproblem family of origin.

From: Maris, Berman, Silverman, Comprehensive Textbook of Suicidology.



## DEFINITION OF SUICIDE - 2

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- "Currently in the Western world, suicide is a conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which the suicide is perceived as the best solution."
- from: Edwin Shneidman, Ph.D., Suicide as Psychache: A Clinical Approach to Self-Destructive Behavior. Northvale, New Jersey: Jason Aronson, Inc. 1993, (Page 4)



## THE TEN COMMONALITIES OF SUICIDE

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**I. The common  
purpose of suicide  
is to seek a  
solution.**



## THE TEN COMMONALITIES OF SUICIDE

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**II. The common  
goal of suicide is  
cessation of  
consciousness.**



## THE TEN COMMONALITIES OF SUICIDE

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**III. The common  
stimulus in suicide is  
unendurable  
psychological pain.**



## THE TEN COMMONALITIES OF SUICIDE

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**IV. The common  
stressor in suicide is  
frustrated  
psychological needs.**



## THE TEN COMMONALITIES OF SUICIDE

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**V. The common  
emotion in suicide  
is hopelessness-  
helplessness.**



## THE TEN COMMONALITIES OF SUICIDE

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**VI. The common  
internal attitude in  
suicide is  
ambivalence.**

**VII. The common  
cognitive state in  
suicide is  
constriction.**

**VIII. The  
common action in  
suicide is escape  
(egression).**



## THE TEN COMMONALITIES OF SUICIDE

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**IX. The common  
interpersonal act in  
suicide is  
communication of  
intention.**



## THE TEN COMMONALITIES OF SUICIDE

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**X. The common  
consistency in  
suicide is life-long  
coping patterns.**

# A New Commonality (from Charles Vorkoper)



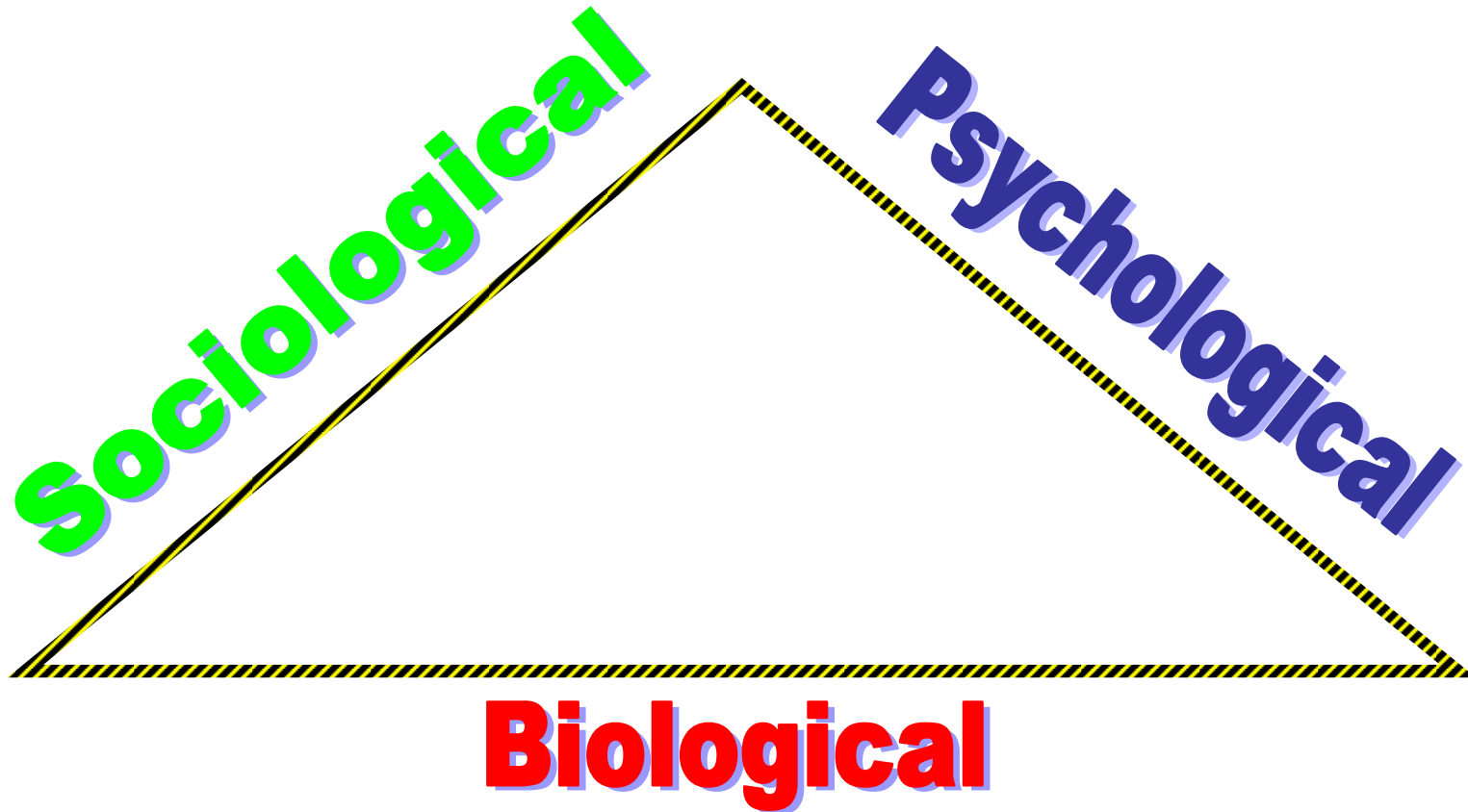
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***xI. The common  
quality in  
suicide is  
drama.***



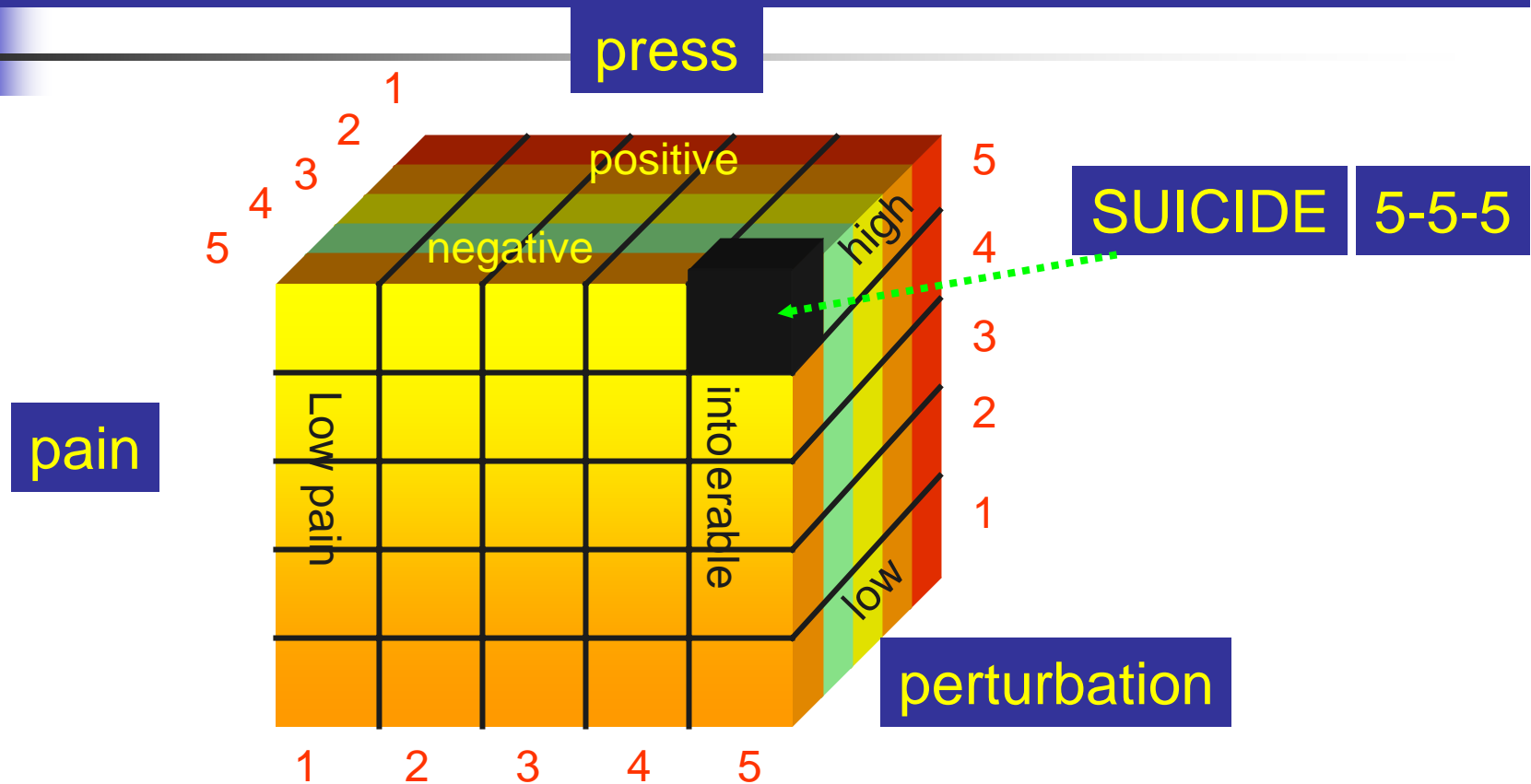
# Understanding the Suicidal Mind

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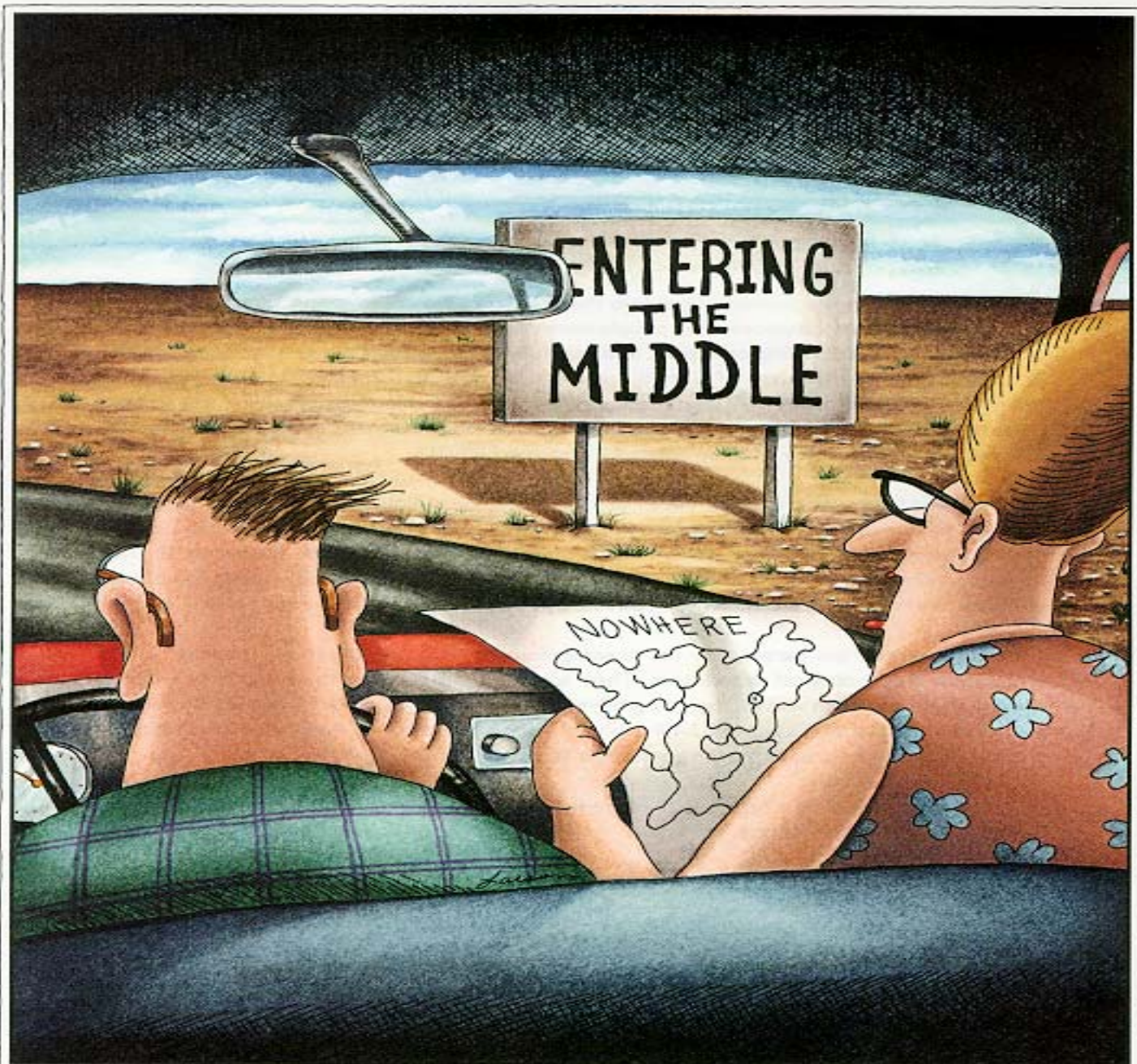


Major Theoretical Approaches

# Shneidman's Cubic Model of Suicide



(Shneidman, 1987)



"Well, this is just going from bad to worse."



# Suicide: A Major Public Health Issue – Some people die

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- Suicidal deaths *officially* account for more than 29,000 lives per year in the United States.
- In Texas there are roughly 2,000 death by suicide annually.
- Suicide is now the 11<sup>th</sup> leading cause of death in the United States (consistently greater than homicide or AIDS-related mortality).
- Every 17 minutes another American dies by suicide.
- Each day approximately 86 Americans will die by suicide.



# The Full Spectrum of Suicidality: Attempts, Ideation, and Survivors

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- It is estimated that there are approximately 765,000 suicide attempts per year in the United States
- While it is virtually impossible to estimate empirically, we believe that literally millions of American have serious suicidal thoughts.
- If every suicide immediately affects 6 family members or friends, then 1 out of every 59 Americans loses someone to suicide each year (i.e., there are an estimated 180,000 new “suicide survivors” each year in the US).



# Suicide Ranked by Leading Cause of Death - 1992

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- Ages 10-14 – Suicide is 4<sup>th</sup>
- Ages 15-24 – Suicide is 3<sup>rd</sup>
- Ages 25-34 – Suicide is 4<sup>th</sup>
- Ages 35-44 – Suicide is 5<sup>th</sup>
- Ages 45-54 – Suicide is 7<sup>th</sup>
- Ages 55-64 – Suicide is 9<sup>th</sup>
- Ages 65+ - Suicide is 12<sup>th</sup> or 13<sup>th</sup> (?)
- All Ages – Suicide is 9<sup>th</sup>
- Remember: These people are a small part of the suicide problem.



# CHARACTERISTICS OF FAMILIES WITH A SUICIDAL POTENTIAL (Table 5.3) Page 58

from, Richman, Joseph, Ph.D., [Family Therapy for Suicidal People,](#)

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- I. An inability to accept necessary change
  - a. An intolerance for separation
  - b. A symbiosis without empathy
  - c. A clinging to early attachments at the expense of later ones
  - d. An inability to mourn



## CHARACTERISTICS OF FAMILIES WITH A SUICIDAL POTENTIAL - 2

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- II. Role and interpersonal conflicts, failures and fixations
- III. A disturbed family structure
  - a. A closed family system
  - b. A prohibition against intimacy outside the family
  - c. An isolation of the potentially suicidal person within the family
  - d. A quality of family fragility



## CHARACTERISTICS OF FAMILIES WITH A SUICIDAL POTENTIAL – 3

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- I. Unbalanced or one-sided intra-familial relationships
  - a. A specific kind of scapegoating
  - b. Double-binding relationships
  - c. Sadomasochistic relationships
  - d. Ambivalent relationships



## CHARACTERISTICS OF FAMILIES WITH A SUICIDAL POTENTIAL - 4

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- II. Affective difficulties
  - a. A one-sided pattern of aggression
  - b. A family depression



## CHARACTERISTICS OF FAMILIES WITH A SUICIDAL POTENTIAL - 5

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- III. Transactional difficulties
  - a. Communication disturbances
  - b. An excessive secretiveness



## CHARACTERISTICS OF FAMILIES WITH A SUICIDAL POTENTIAL - 6

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- IV. An intolerance for crises



# Risk Factors for Suicide

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- Previous Suicide Attempt
- History of Mood Disorder including Schizophrenia and Manic Depression
- Victim of sexual abuse, particularly incest, domestic violence, or other assault.
- Witness to a suicide
- History of addiction
- History of unnecessary risk-taking or self-destructive behaviors
- Sudden change in normal behavior or attitude
- Presence of a suicide plan
- Presence of firearms



# COMPULSIVE GAMBLERS AS SUICIDAL RISKS

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- Levels of suicide ideation associated with:
  - Greater gambling severity
  - Gambling escape
  - Dissociation and attention seeking
  - Impulsivity
  - Generalized dissociative experience

From: Ledgerwood, David and Petry, Nancy M, "Gambling and Suicidality in Treatment-Seeking Pathological Gamblers," "Journal of Nervous & Mental Disorders & Mental Disease," 192(10): 711-714.



# Research on Suicide Ideation and Attempts Among Gamblers

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- In a cross-national U.S. study of GA, 48% of the sample reported suicide ideation – 21% had attempted suicide. Suicidal gamblers – more serious gamblers, had gambled at an earlier age, were more likely to seek to support their gambling, and had more disturbed/addicted families.

From: Frank, D.R., Taff, M.L., & Boglioli, L.R. (1991) "Suicidal behavior among members of Gamblers Anonymous." "Journal of Gambling Studies," 7(3), 249-254.



# Research on Gamblers and Suicidal Behaviors - 2

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- In a randomly-selected community survey in Edmonton, thirty life-time pathological gamblers were identified from 7,214 interviews. Gamblers had a high rates of comorbidity with other psychiatric disorders and 13.3% had made suicide attempts.

From: Gland, R.C., Newman, S.C., Orn, H., & Stebelsky, G. (1993) "Epidemiology of pathological gambling in Edmonton," "Canadian Journal of Psychiatry," 38(2), 108-112.



# Research on Gamblers and Suicidal Behaviors - 3

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- In a study of 50 male pathological gamblers in an inpatient gambling treatment program in a VA hospital in Cleveland, 30% had made a severe/extreme/lethal suicide attempt, and 50% reported moderate, mild, and slight suicide ideation. 76% were diagnosed with major depressive disorder.

From: McCormick, R.A., Russo, A.M., Ramirez, L.F., & Taber, J.I. (1984), "Affective disorders among pathological gamblers seeking treatment." "American Journal of Psychiatry," 141(2), 215-218.



# Research on Gamblers and Suicidal Behaviors - 4

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- A study done by the Baton Rouge Crisis Intervention Center in 1995 reports a dramatic increase in problem gambling related calls, after the state government legalized more forms of gaming that allowed in any other state. Calls related to gambling jumped from 1% (prior to 1992 legislation) to 10%. Of these gambling-related calls, 9.3% had suicidal content.

From: Campbell, F.R. (1995). "Gambling + Suicide = Crisis Centers: Are You in or Out?" "Proceedings of the American Association of Suicidology." 28, [17 p.].



# Reasons for Not Seeking Professional Help Given by People Who Have Considered Suicide

Reason	% Agreeing
Wanted to solve the problem on my own	81
Thought the problem would get better by itself	62
Getting help too expensive	62
Unsure about where to go for help	57
Help probably would not do any good	52
Would take too much time or be inconvenient	43
Health insurance would not cover treatment	38
Went in the past, but did not help	33
Concerned about what others might think	29
Problem went away by itself, so did not need help	24
Scared about being put in the hospital against my will	19
Not satisfied with available services	19
Could not get an appointment	10
There was a language problem	5



# Most Important Warning Sign

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- *Client says “Yes” when asked: “Are you thinking about suicide (killing yourself, etc.)?”*



# Assessment Questions

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- Does the person have a plan?
- Is the plan lethal? Be cautious with this one!
- Does the person have the means to be lethal?
- Does the person have a mental or physical illness history?
- Have they attempted before? When? How often?
- Are there support people? Are they willing to help?
- Has there been a loss? When?
- Addictive behavior – degree of severity?



# TREATMENT

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- Richman: The job of the therapist is to restore hope by providing an alternative solution in the context of a genuine, caring relationship. Anticipating resistance, he attempt to involve the family in treatment from the beginning.... He seeks to decrease separation anxiety and increase individuation and competence.
- From: Richman, Prevention: Elder Suicide..



# Treatment Tasks for Highly Suicidal Persons

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- 1. Stimulus (unbearable pain): Reduce the pain
- 2. Stressor (frustrated needs): Fill the frustrated needs
- 3. Purpose (to seek a solution): Provide a viable answer
- 4. Goal (cessation of consciousness): Indicate alternatives
- 5. Emotion (hopelessness-helplessness): Give transfusion of hope



## Treatment Tasks - 2

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6. Internal attitude (ambivalence): **Play for time**
7. Cognitive state (constriction): **Increase the options**
8. Interpersonal act (communication of intention): **Listen to the cry, involve others**
9. Action (egression): **Block the exit**
10. Consistency (with life-long patterns): **Invoke previous positive patterns of successful coping**



# THE SUICIDAL PERSON

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Is in a crisis state

Is in an altered state



# FIRST STEP: CRISIS RESPONSE

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- Make empathic connection
- Assess level and content of situation
- Connect with the person's identification of the problem
- Explore resources – person's and community's
- Agree about the person's next steps
- Agree on a follow-up plan.



# Crisis Response Plan Pointers

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- Be specific
  - when to use, steps to take, where to go, what numbers to call
- Be concrete
- Ensure safety, remove access, availability
- Make it accessible
  - put on a card
- Practice, role play
- Periodically review and update



# Crisis Services and Availability

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- Clear crisis management plan
  - integrated into informed consent statement
  - use of crisis cards
- Accessible referral sources
  - clarity of identifying those requiring long-term care
  - out of center referrals following crisis stabilization



# *No-Suicide Contracts*

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- Have limited value and meaning
- No empirical support
- Pose a potential liability
- More a reflection of clinician anxiety and lack of control
- Not actually a therapeutic intervention
- Hidden messages
  - blame, control, *open* communication



# Why do we use no-suicide contracts?

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- Fear of lawsuits
- Clinician attitudes, believed successful by most clinicians
- Interpersonal and unconscious factors
  - control
  - Predictability



# Options to Contracts

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- Ask about suicide
- Assess with care
- Locate allies in the person's life
- Invite decision, not contract (this is about the client, not the clinician)
- Consult – suicide is very complex



# Suicide and Clinicians: The "Other" Patient

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- Survey data suggest that one in two psychiatrists and one in five psychologists will lose a patient to suicide in the course of their career (Chemtob et al., 1988).
- No other patient behavior generates more stress and fear among mental health professionals than a potential suicide (Pope & Tabachnick, 1993).
- In recent years there have been exponential increases in suicide-related malpractice liability law suits against mental health clinicians (Jobes & Berman, 1993).
- Malpractice lawsuits are one of the top ten growing areas of contemporary litigation (Welch, 2000).
- Over 50% of family members who survive a loved one's suicide consider contacting an attorney; 25% actually engage a lawyer (Peterson, Luoma, & Dunne, 2000).



# Implications for Clinicians

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- Suicidality is a remarkably common clinical presentation that generates a great deal of fear and anxiety among mental health professionals who typically receive little, if any, formalized training in suicide risk assessment and treatment (Bongar, 1991).
- Given increasing malpractice litigation for wrongful death following a suicide, it is striking that clinicians often fail to even ask about, thoroughly assess, and document a patient's potential suicide risk (Coombs et al., 1992).



# Clinician's Self-Care: Before

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- Self-knowledge
  - Education
  - Peer Support
  - Established and Regular Consultation
  - Family Support
  - Legal Support
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- —from: Vorkoper and Meade, "Loss of a client by suicide: Suggestions before and after a client suicide," a chapter in: The Couple and Family Therapist's Notebook, Published, September, 2005.



# Clinician's Self-Care: After

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- Let yourself be in shock
- Lean on your personal support
- Consult – peers, insurance company, attorney, consultant
- Be open with your family
- Take time off to grieve
- Consult

—from: Vorkoper and Meade, "Loss of a client by suicide: Suggestions before and after a client suicide,"  
Published in: The Couple and Family Therapist's Notebook, September, 2005



# The Standard of Care

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- That degree of care which a reasonably prudent person or professional should exercise in same or similar circumstances (Black, 1979, p. 1260)
- The duty of therapists to exercise adequate care and skill in diagnosing suicidality is well established (see *Meier v. Ross General Hospital*, 1968).
- When the risk of self-injurious behavior is identified an additional duty to take adequate precautions arises (*Abille v. United States*, 1980; *Pisel v. Stamford Hospital*, 1980).
- When psychotherapists fail to meet these responsibilities, they may be held responsible for injuries that result (Meyer, Landis, & Hays, 1988, p. 38).

Bongar, B., Berman, A. L., Maris, R. W., Silverman, M. M., Harris, E. A., & Packman, W. L. (eds.). *Risk Management with Suicidal Patients*. New York: Guilford Press.



# *Summary of Risk Management and Malpractice Liability Considerations*

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- Know general principles of clinical risk management
  - Ethics and legal statutes
  - Learning about malpractice
  - Confidentiality
  - Patient's informed consent
  - Business practices
  - Consultation
  - Record keeping
  - Malpractice insurance
  
- Know issues pertaining specifically to suicide and malpractice liability
  - Legal awareness
  - Policies and procedures statement
  - Clinical competence
  - Documentation
  - Establishing resources

Source: Jobes & Berman (1993)



# Supervision/Consultation

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- Supervision program
  - Get clear about definitional issues
  - Develop consistency in risk assessment
  - Regularly deal with: individual attitudes, beliefs, countertransference management and understanding
  - Assess clinician suicide issues
- Case conferences